MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13025 — 12982 Reg. Dist. No.

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL OXFORD
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): HI-WAY

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MD — b. COUNTY: TALBOT
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X OXFORD
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ERNEST — Middle BENJAMIN — Last BANKS
4. DATE OF DEATH: Month NOV — Day 13 — Year 1959
5. SEX: MALE
6. COLOR OR RACE: COL
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov 3, 1900
9. AGE (In years last birthday): 59 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER
10b. KIND OF BUSINESS OR INDUSTRY: SEAFOOD
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: ERNEST BANKS SR.
14. MOTHER'S MAIDEN NAME: STELLA
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: 220-01-6390
17. INFORMANT: ROBERT BANKS — Address: OXFORD, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): RUPTURED VISCUS — INTERVAL BETWEEN ONSET AND DEATH
816X
DUE TO (b): AUTO ACCIDENT
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): DRIVER OF CAR IN COLLISION WITH ANOTHER
20c. TIME OF INJURY: Hour 09:12 a. m. p. m. — Month, Day, Year 11-13-59
20d. INJURY OCCURRED: While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HIWAY TO
20f. (City or town) NR OXFORD (County) TALBOT (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis Welty M.D.
EXAMINER'S NAME (Type): WELTY
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-16-59

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 11-18-59
22c. NAME OF CEMETERY OR CREMATORY: OXFORD CEM.
22d. LOCATION (City, town, or county) (State): OXFORD, MD.

23. FUNERAL DIRECTOR'S SIGNATURE: JAMES B. DASHIELDS — ADDRESS: EASTON, MD.
24a. REC'D BY REGISTRAR DATE: NOV 19 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

FOR STATE HEALTH DEPT.

6:40 AM RC 12997 Item 7 FilmG252 11-25-59 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12983 Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 6 hrs 30 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Easton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Queenanne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville 17X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First James Middle Edward Last Banks
4. DATE OF DEATH Month November Day 14 Year 1959
5. SEX M
6. COLOR OR RACE Negro
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH March 10 1921
9. AGE (In years last birthday) 38 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Tandy BANKS
14. MOTHER'S MAIDEN NAME Gertrude Jones

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO: 221-14-7978
17. INFORMANT Address Sarah Banks, Easton, md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Will Follow — INTERVAL BETWEEN ONSET AND DEATH
DUE TO (b) Gun Shot Wound Abdomen
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 981X
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Argument was Shot
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 11 13 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) Centreville (County) QA (State) Md

21. I certify that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☒, Undetermined manner ☐

ACTUAL SIGNATURE C. R Layton M.D.
EXAMINER'S NAME (Type) C. R Layton
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 11-14-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/19/59
22c. NAME OF CEMETERY OR CREMATORY Roseville Cem.
22d. LOCATION (City, town, or county) Centreville (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE James L Dashiell Easton, Md. ADDRESS
24a. REC'D BY REGISTRAR DATE NOV 19 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12998 — 12984 — Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 23days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro 05x-2
d. STREET ADDRESS: None
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: Elizabeth — Middle: E — Last: Bilbrough

4. DATE OF DEATH: November 30 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 13 1884

9. AGE (In years last birthday): 74 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: House work

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Charles Shockley

14. MOTHER'S MAIDEN NAME: Catherine DEAN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: Charles Bilbrough — Address: Greensboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute myocardial infarction — INTERVAL BETWEEN ONSET AND DEATH: 22 days

420.1

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-8, 1959, to 11-30, 1959, that I last saw the deceased alive on 11-30, 1959, and that death occurred at 9:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Robert W. Trever M.D. — ADDRESS (Street, city or town, state): 202 Dover St. Easton, Md. — DATE SIGNED: 11-30-59

PHYSICIAN'S NAME (Type): Easton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 12-3-59 — 22c. NAME OF CEMETERY OR CREMATORY: Greensboro — 22d. LOCATION (City, town, or county) (State): Greensboro Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. C. Boulden — ADDRESS: Greensboro, Md.

24a. REC'D BY REGISTRAR DATE: DEC 3 '59 — 24b. REGISTRAR'S SIGNATURE: Caitlin S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12999 — Reg. Dist. No. — 12985

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1. PLACE OF DEATH — a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 3 days.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: EASTON Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Kent
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Chestertown 1437-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: HIRAM — Middle: — Last: Biscoe

4. DATE OF DEATH: Month: Nov — Day: 4 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Dec 29 1889

9. AGE (In years last birthday): 69 yrs.
IF UNDER 1 YEAR — Months: — Days: — IF UNDER 24 HRS. — Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): farmer

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Biscoe

14. MOTHER'S MAIDEN NAME: Martha Nicherson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 219-36-6394

17. INFORMANT: Thomas Biscoe, son — Address: Centreville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary gangrene — INTERVAL BETWEEN ONSET AND DEATH:
163X
DUE TO (b): Carcinoma of lung
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Pathology Dept, 19____, to ____, 19____, that I last saw the deceased alive on Pathology Dept, 19____, and that death occurred at 7 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: E.C.H. Schmidt M.D. — ADDRESS (Street, city or town, state): 219 S. Washington St. Easton, Maryland — DATE SIGNED: 4-Nov-59

PHYSICIAN'S NAME (Type): E.C.H. Schmidt

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — 22b. DATE THEREOF: 11/7/59 — 22c. NAME OF CEMETERY OR CREMATORY: Saddlerhills — 22d. LOCATION (City, town, or county) (State): Saddlerhills Md

23. FUNERAL DIRECTOR'S SIGNATURE: Edgar L Lane — ADDRESS: Church Hill, Md

24a. REC'D BY REGISTRAR — DATE: NOV 9 '59 — 24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,9 FilmG252 11-23-59 et

12986

13009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 100 Hammond St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton, Md.
d. STREET ADDRESS 100 Hammond St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Katie Middle Blackson Last
4. DATE OF DEATH Month 11 Day 7 Year 1959

5. SEX Female
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH June Unknown
9. AGE (In years last birthday) 91 ? yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Domestic
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Miller
14. MOTHER'S MAIDEN NAME LARUA Bigual

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address Clifford Blackston, Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Acute Myocardial Infarction	10 minutes
DUE TO		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)	Coronary Artery Disease	
DUE TO (c)	Generalized Arteriosclerosis	

420.1

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/7, 19 59, to 11/7, 19 59, that I last saw the deceased alive on 11/7, 19 59, and that death occurred at 2045 M, from the causes and on the date stoted above.

ACTUAL SIGNATURE L. J. Eglseder M.D.
ADDRESS (Street, city or town, state) 12 N. Hanson St
DATE SIGNED 11/10/59
PHYSICIAN'S NAME (Type) L. J. Eglseder M.D. Easton Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11/10/59
22c. NAME OF CEMETERY OR CREMATORY Richards
22d. LOCATION (City, town, or county) Easton, (State) Md.

23. FUNERAL DIRECTOR'S SIGNATURE James B. Corkell
ADDRESS Easton, Md.
24a. REC'D BY REGISTRAR DATE NOV 19 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director. page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13026 — Reg. Dist. No. 12987

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairbank, Md.
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: ----

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairbank
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First WILLIAM — Middle R. — Last BROWN
4. DATE OF DEATH: Month November — Day 26, — Year 1959
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Nov. 11, 1873
9. AGE (In years last birthday): 86 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Waterman
10b. KIND OF BUSINESS OR INDUSTRY: Seafood
11. BIRTHPLACE (State or foreign country): Trappe, Maryland
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): ----
16. SOCIAL SECURITY NO.:
17. INFORMANT — Address: Mrs. Laura Kapisak, Fairbank, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1 wk
DUE TO (b) Cancer of stomach — 5 mo.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
161X
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Senile dementia
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐
20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ---- 19 50, to Nov 26 19 59, that I last saw the deceased alive on Nov 26 19 59, and that death occurred at 4 P M, from the causes and on the date stated above.
ACTUAL SIGNATURE: Guy M Reeser Sr M.D. — ADDRESS (Street, city or town, state): Tilghman Md — DATE SIGNED
PHYSICIAN'S NAME (Type): GUY M. REESER, SR., M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 29, 1959
22c. NAME OF CEMETERY OR CREMATORY: Tilghman Cemetery
22d. LOCATION (City, town, or county) (State): Tilghman, Maryland
23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: S. Hamilton Harrison, St Michaels md
24a. REC'D BY REGISTRAR DATE: DEC 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12988

1

FOR STATE HEALTH DEPT. M

13001

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b minutes
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Baltimore
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3V01-4
d. STREET ADDRESS 713 S. Hanover
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Claresa Middle M. Last Bryan
4. DATE OF DEATH Month 12 Day 30 Year 1959
5. SEX F
6. COLOR OR RACE Col
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 5/4/11
9. AGE (In years last birthday) 48 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer
10b. KIND OF BUSINESS OR INDUSTRY Factory
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Marshall
14. MOTHER'S MAIDEN NAME Annie White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 214-07-7461
17. INFORMANT Address Mary Marshall Cambridge

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage — INTERVAL BETWEEN ONSET AND DEATH
331X
DUE TO (b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Louis Welty M.D.
EXAMINER'S NAME (Type) WELTY
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED 12-1-59

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12-4-59
22c. NAME OF CEMETERY OR CREMATORY Bethel Cem.
22d. LOCATION (City, town, or county) (State) Cambridge, Md.

23. FUNERAL DIRECTOR'S SIGNATURE James E. Caulk
ADDRESS Easton, Md.
24a. REC'D BY REGISTRAR DATE DEC 2 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME 5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13002 — Reg. Dist. No. 12989

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 9 da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Denton
d. STREET ADDRESS: 309 Gay St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

05x-2

080

3. NAME OF DECEASED (Type or print): First: MARY — Middle: L — Last: Bunney
4. DATE OF DEATH: Month: 11 — Day: 9 — Year: 1959
5. SEX: Fe
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Oct 21, 1899
9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK
10b. KIND OF BUSINESS OR INDUSTRY: LUMBER
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Samuel Lewis
14. MOTHER'S MAIDEN NAME: Ida Hubbard

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Robert H. Bunney — Address: Denton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of colon — INTERVAL BETWEEN ONSET AND DEATH
153.8
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 1:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ellis Schmidt M.D. — ADDRESS (Street, city or town, state): 19 S Washington St. Easton Md. — DATE SIGNED: 11/9/59

PHYSICIAN'S NAME (Type): E. C. H. Schmidt — Canton 16, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 13, 1959
22c. NAME OF CEMETERY OR CREMATORY: DENTON
22d. LOCATION (City, town, or county) (State): DENTON MD.

23. FUNERAL DIRECTOR'S SIGNATURE: J. Vogel Thomas Son — ADDRESS: Denton

24a. REC'D BY REGISTRAR DATE: NOV 24 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Truax

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8,21 FilmG 254 1-14-60 et

13003

CERTIFICATE OF DEATH

Reg. Dist. No. 14153

1. PLACE OF DEATH
a. COUNTY: T albot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Eas Eaton
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 605 Dover st.

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 EASTON
d. STREET ADDRESS: 605 Dover st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harriett — Middle: — Last: Burton

4. DATE OF DEATH: Month: 12 — Day: 18 — Year: 1959

5. SEX: F

6. COLOR OR RACE: Col

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 27, 1883

9. AGE (In years last birthday): 76 (yrs.)
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FACTORY Labor

10b. KIND OF BUSINESS OR INDUSTRY: Fish FACTORY

11. BIRTHPLACE (State or foreign country): MARYland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Charles Randoph

14. MOTHER'S MAIDEN NAME: Katherine Pinckney

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Thomas — Address: Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Vascular Accident — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Hypertensive arteriosclerotic
DUE TO (c): Cardio Vascular Disease

443X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Month, Day, Year; Hour a. m. p. m.; 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1/30, 19 59, to 11/18, 19 59, that I last saw the deceased alive on 11/30 11-18 59, and that death occurred at 1 A M, from the causes and on the date stated above.

ACTUAL SIGNATURE: L. J. Eglseder M.D. — ADDRESS (Street, city or town, state): 12 N. HANSON ST — DATE SIGNED:

PHYSICIAN'S NAME (Type): Ludwig J. Eglseder MD. EASTON, MARYLand

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/21/59
22c. NAME OF CEMETERY OR CREMATORY: Richards Cemetery
22d. LOCATION (City, town, or county) (State): Easton, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James B. Schiell, Easton, Md. — ADDRESS:

24a. REC'D BY REGISTRAR DATE: DEC 17 '59

24b. REGISTRAR'S SIGNATURE: Audrey S. Kunkel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13004

12990 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton.
c. LENGTH OF STAY IN 1b 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton
d. STREET ADDRESS 131 Hammond Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Mamie Middle Lost Copper

4. DATE OF DEATH Month November Day 3 Year 19 59

5. SEX F
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH July 15, 1885
9. AGE (In years last birthday) 74 yrs.
IF UNDER 1 YEAR: Months Days
IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Housework
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Philip Mooney
14. MOTHER'S MAIDEN NAME Vannie Copper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address daughter -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolism — INTERVAL BETWEEN ONSET AND DEATH

465 ×

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Thrombosis left leg.
DUE TO (c) Recti-Sigmoid abcess

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Nov 3, 19 59, and that death occurred at 11:05 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE E.C.H. Schmidt M.D. ADDRESS (Street, city or town, state) 219 S. Washington St. Easton, Md. DATE SIGNED 11/10/59

PHYSICIAN'S NAME (Type) E.C.H. Schmidt Easton 16, Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 11-7-59
22c. NAME OF CEMETERY OR CREMATORY Richards Cemetery
22d. LOCATION (City, town, or county) (State) Easton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE James B. Robbins ADDRESS Easton, Md.
24a. REC'D BY REGISTRAR DATE NOV 19 '59
24b. REGISTRAR'S SIGNATURE Arthur L. Kuhns

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13005

12991 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 16 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Easton Memorial Hosp.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md.
b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston 05X-2
d. STREET ADDRESS Near Johns
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First Riley Middle Charles Last Dodson

4. DATE OF DEATH Month Nov Day 10 Year 1959

5. SEX Male

6. COLOR OR RACE Col.

7. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ]

8. DATE OF BIRTH Oct 13 1895

9. AGE (In years last birthday) 64 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman

10b. KIND OF BUSINESS OR INDUSTRY Canning Factory

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Edward Dodson

14. MOTHER'S MAIDEN NAME Jane Jenkins.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 220-05-7364

17. INFORMANT Address: Ruth D. Hubbard, Hurlock, Maryland, RFD#1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH ?

DUE TO (b) Carcinoma pancreas — 1 year ?

DUE TO (c)

157X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work [ ] Not while at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct 27, 1959 to 11/10, 1959, that I last saw the deceased alive on 11/10, 1959, and that death occurred at 1205 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE J. H. P. Garnett M.D. ADDRESS (Street, city or town, state) Easton Md DATE SIGNED 11/17/59

PHYSICIAN'S NAME (Type) J. H. P. GARNETT

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial

22b. DATE THEREOF Nov. 14, 1959

22c. NAME OF CEMETERY OR CREMATORY Johns Cemetery

22d. LOCATION (City, town, or county) (State) Near Preston, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE J. J. Frampton & Son ADDRESS Federalsburg, Maryland

24a. REC'D BY REGISTRAR DATE NOV 19 '59

24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13027

CERTIFICATE OF DEATH

12992

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman
c. LENGTH OF STAY IN 1b 5 years
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Alice Middle H. Lost Frampton
4. DATE OF DEATH Month 11 Day 7 Year 1959
5. SEX Female
6. COLOR OR RACE W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 2-8-1895
9. AGE (In years last birthday) 64 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House wife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Baltimore Md.
12. CITIZEN OF WHAT COUNTRY? U. S. A.
13. FATHER'S NAME Isaac A Harrison
14. MOTHER'S MAIDEN NAME Sarah E. Lowery
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-28-5217
17. INFORMANT Address Mrs. Muriel S. Frampton Tilghman Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary occlusion
174X
DUE TO (b) Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c) Generalized arteriosclerosis
INTERVAL BETWEEN ONSET AND DEATH Seconds / 1 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Coronary artery disease 5 yrs
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__ to Nov 7, 19 59 that I last saw the deceased alive on Nov 7, 19 59, and that death occurred at 0450 M, from the causes and on the date stated above.

ACTUAL SIGNATURE Guy M Reeser Sr M.D. ADDRESS (Street, city or town, state) TILGHMAN Md DATE SIGNED Nov 8 1959
PHYSICIAN'S NAME (Type) GUY M REESER SR TILGHMAN Md

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Nov. 10, 59
22c. NAME OF CEMETERY OR CREMATORY Woodlawn
22d. LOCATION (City, town, or county) (State) Baltimore Md.

23. FUNERAL DIRECTOR'S SIGNATURE J. Linda Moore ADDRESS Tilghman Md
24a. REC'D BY REGISTRAR DATE NOV 10 '59
24b. REGISTRAR'S SIGNATURE Cinthia S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13006

12995 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland b. COUNTY: Talbot

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton

c. LENGTH OF STAY IN 1b: 3 years

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Easton

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Dover & Harrison Sts.

d. STREET ADDRESS: Dover & Harrisons Sts.

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First BEULAH Middle BERKSHIRE Last GUNTHER

4. DATE OF DEATH: Month Nov. Day 2, Year 1959

5. SEX: female

6. COLOR OR RACE: white

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: July 11, 1875

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Kirtley Yowell Berkshire

14. MOTHER'S MAIDEN NAME: Emma Allan

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mr. Frank Gunther Address: Easton, Maryland

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE — INTERVAL BETWEEN ONSET AND DEATH: 2 HRS.

420.0

DUE TO (b) ARTERIO—SCLEROTIC HEART DISEASE — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1957, to Nov. 2, 1959, that I last saw the deceased alive on Nov. 2, 1959, and that death occurred at 7 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald F. Bartley M.D. ADDRESS (Street, city or town, state): 97 N. Hanson St. Easton Md. DATE SIGNED: 11-2-59

PHYSICIAN'S NAME (Type): Donald F. Bartley

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 4, 1959

22c. NAME OF CEMETERY OR CREMATORY: Spring Hill Cemetery

22d. LOCATION (City, town, or county) (State): Easton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Maurice E. Newnam & Son ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: NOV 6 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kinnear

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 1 and page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13007

CERTIFICATE OF DEATH

12995

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 8mo 4da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Easton Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Queen Anne
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Queenstown 17X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First: William — Middle: E — Last: Hammond

4. DATE OF DEATH: Month: Nov — Day: 13 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 13 1885

9. AGE (In years last birthday): 74 yrs.

IF UNDER 1 YEAR / IF UNDER 24 HRS. — Months / Days / Hours / Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Mr Edwin F. Hammond

14. MOTHER'S MAIDEN NAME: Mary Bishop

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 217-36-0607

17. INFORMANT: A. B Hammond — Address: Brother Queenstown

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of the stomach c

DUE TO (b): Generalized Carcinomatosis

DUE TO (c):

151X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 Months +

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from May, 1959, to 11/13, 1959, that I last saw the deceased alive on 11/13/59, 19, and that death occurred at 3:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Wm. D. Noble M.D.

ADDRESS (Street, city or town, state): Easton Md

DATE SIGNED: 11/16/59

PHYSICIAN'S NAME (Type): WILLIAM D NOBLE EASTON MD

22a. BURIAL, ~~CREMATION~~, ~~REMOVAL~~ (Specify): Burial

22b. DATE THEREOF: Nov. 16-59

22c. NAME OF CEMETERY OR CREMATORY: Chesterfield

22d. LOCATION (City, town, or county) (State): Centreville Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: Jos. W. Baxter Jr. of Baxter Bros. — ADDRESS: Centreville Maryland

24a. REC'D BY REGISTRAR DATE: NOV 19 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13008

12997

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ~~5 West St.~~ Mem Hosp

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Easton, Md.
d. STREET ADDRESS: 2 West St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: William Middle: Alexander Last: Harris

4. DATE OF DEATH: Month: November Day: 19 Year: 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 8, 1959

9. AGE (In years last birthday): ~~3 Month~~ yrs.
IF UNDER 1 YEAR: Months: 3 Days: 11
IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Harris

14. MOTHER'S MAIDEN NAME: Dorothy Elizabeth McDaniel

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Father Address: Easton, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Viral Pneumonitis — INTERVAL BETWEEN ONSET AND DEATH:
492 ✓
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: a. m. / p. m. Month, Day, Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Kenneth Welty M.D.
EXAMINER'S NAME (Type): WELTY
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-19-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 11/21/59
22c. NAME OF CEMETERY OR CREMATORY: Richardson Cem.
22d. LOCATION (City, town, or county) (State): Easton Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James B. Dashiell ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR DATE: DEC 1 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

2080263X V4

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13009 — Reg. Dist. No. 12998

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: MARYLAND — b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): FEDERALSBURG — 05 X-2
d. STREET ADDRESS: R.F.D #1, BOX 75
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ANNA — Middle GERTRUDE — Last HAYNES

4. DATE OF DEATH: Month NOVEMBER — Day 4 — Year 19 59

5. SEX: Female
6. COLOR OR RACE: NEGRO
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY 5, 1901
9. AGE (In years last birthday): 58 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework
10b. KIND OF BUSINESS OR INDUSTRY: Home
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Numbers TRUXON
14. MOTHER'S MAIDEN NAME: EMMA STANFORD Caroline Co.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT: LOUISE HAYNES — DAUGHTER — SAME — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH
420.1
DUE TO (b): Coronary occlusion.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year — Hour o. m. p. m. — 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____ to _____, 19____, that I last saw the deceased alive on Oct 29 1959, and that death occurred at 3 10 A. M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Ed H Schmidt M.D. — ADDRESS (Street, city or town, state): 219 S. Washington St. Easton, Maryland — DATE SIGNED: Nov 9 59

PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 7, 1959
22c. NAME OF CEMETERY OR CREMATORY: Saint Paul Cemetery
22d. LOCATION (City, town, or county) (State): Near Federalsburg, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: J J Frampton Son — ADDRESS: Federalsburg Md.
24a. REC'D BY REGISTRAR DATE: NOV 9 '59
24b. REGISTRAR'S SIGNATURE: Clarence E. Travers

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be required by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12999

13010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: Maryland
b. COUNTY: TALBOT

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 2 hrs 10 min

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Wye Mills, Md. 17x-2

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Easton Memorial Hosp.

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

080

3. NAME OF DECEASED (Type or print): First: ORA — Middle: May — Last: HUMPHREYS Humphreys

4. DATE OF DEATH: Month: Nov — Day: 3 — Year: 1959

5. SEX: Fe.

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct 29 1914

9. AGE (In years last birthday): 45 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): H.W.

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Johnson

14. MOTHER'S MAIDEN NAME: Nettie Grover

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: MRS. ORA May Gibson daughter same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): CEREBRAL VASC. HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 9 HRS

443 X

DUE TO (b): HYPERTENSIVE CARDIO-VASC. DISEASE — YEARS

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour o. m. p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-3- 1959, to 11-3- 1959, that I last saw the deceased alive on 11-3- 1959, and that death occurred at 7:20 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Donald F. Bartley M.D. — ADDRESS (Street, city or town, state): 9 N. Hanson St. — DATE SIGNED: 11-3-59

PHYSICIAN'S NAME (Type): DONALD F BARTLEY — Easton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 5, 1959

22c. NAME OF CEMETERY OR CREMATORY: St. Paul's Cem.

22d. LOCATION (City, town, or county) (State): Talbot Co. Md

23. FUNERAL DIRECTOR'S SIGNATURE: A. A. Harkness Son — ADDRESS: Trappe, Md.

24a. REC'D BY REGISTRAR DATE: NOV 5 '59

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13000

13028

1. PLACE OF DEATH
a. COUNTY: TALBOT
STATE: MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RURAL ST. MICHAELS
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: BUENAVISTA NURSING HOME

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): DENTON 05 x-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MARY Middle Last KIMMEY

4. DATE OF DEATH: Month NOV Day 1 Year 1959

5. SEX: F
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: DEC 1, 1890
9. AGE (In years last birthday): 68 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: JOHN L. GEORGE
14. MOTHER'S MAIDEN NAME: MARTHA CARROLL

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: EMORY KIMMEY Address: DENTON, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Cirrhosis of the liver	
DUE TO	581.0	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		
DUE TO		
(c)		

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 1 Sept, 19 59, to 1 Nov, 19 59, that I last saw the deceased alive on 30 Oct, 19 59, and that death occurred at M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Thurston Harrison M.D.
ADDRESS (Street, city or town, state): Easton Maryland
DATE SIGNED: 3 Nov 59

PHYSICIAN'S NAME (Type): THURSTON HARRISON

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: NOV 4, 1959
22c. NAME OF CEMETERY OR CREMATORY: DENTON
22d. LOCATION (City, town, or county): DENTON (State): MD

23. FUNERAL DIRECTOR'S SIGNATURE: J. Wyatt Moore & Son
ADDRESS: Denton Md

24a. REC'D BY REGISTRAR DATE: NOV 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13011

CERTIFICATE OF DEATH

13001

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 33 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Preston 05X-2
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Eugene Middle W Last Lewis

4. DATE OF DEATH Month November Day 20 Year 1959

5. SEX M

6. COLOR OR RACE Col

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH July 9, 1929

9. AGE (In years last birthday) 30 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country) Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME Richard Derricott

14. MOTHER'S MAIDEN NAME Willie Jane Lewis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of the lung — INTERVAL BETWEEN ONSET AND DEATH > 3 mos

163X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Oct. 19, 19 59, to Nov. 20, 19 59, that I last saw the deceased alive on Nov. 20, 19 59, and that death occurred at 7:55 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Robert W. Trever M.D. — ADDRESS (Street, city or town, state) 202 Dover St. — DATE SIGNED 11-23-59

PHYSICIAN'S NAME (Type) ROBERT W. TREVER M.D. — Easton, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF NOV 30 1959 — 22c. NAME OF CEMETERY OR CREMATORY JOHNS HOPKINS MEDICAL SCHOOL — 22d. LOCATION (City, town, or county) (State)

23. FUNERAL DIRECTOR'S SIGNATURE L. Hamilton Harrison — ADDRESS St. Michaels Md

24a. REC'D BY REGISTRAR DATE DEC 1 '59 — 24b. REGISTRAR'S SIGNATURE Arthur L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
1SM 9/SS

1

FOR STATE HEALTH DEPT.

Item 18 Film 252 11-26-59 ams

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13012

13002

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 2/57

1. PLACE OF DEATH
   a. COUNTY: TALBOT — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
   c. LENGTH OF STAY IN 1b: D.O.A.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
   a. STATE: Maryland — b. COUNTY: TALBOT
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Mc Daniel
   d. STREET ADDRESS:
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: G. — Last: Lowe

4. DATE OF DEATH: Month: Nov — Day: 7 — Year: 19 59

5. SEX: Fe

6. COLOR OR RACE: White — MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 26, 1890

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Albert Lowe

14. MOTHER'S MAIDEN NAME: Mary Francis Wrighton

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Carroll Lowe, brother — Address: same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	1. Viral myocarditis	
DUE TO	2. Resolving viral pneumonitis	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b)	3. Nephrosclerosis	
DUE TO (c)	4. Focal hemorrhagic encephalopathy	
	5. Focal fibrosis of the cerebro-arachnoid	

442 X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis J Welty M.D.

EXAMINER'S NAME (Type): WELTY

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 11-9-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: NOV 10, 1959

22c. NAME OF CEMETERY OR CREMATORY: Springhill Cemetery

22d. LOCATION (City, town, or county): Easton (State): Md.

23. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: S. Hambleton Harrison, St Michaels Md

24c. REC'D BY REGISTRAR: DATE NOV 9 '59

24b. REGISTRAR'S SIGNATURE: [illegible] S. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13013

CERTIFICATE OF DEATH

13003 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE Maryland b. COUNTY Talbot

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON

c. LENGTH OF STAY IN 1b 6 da.

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Tilghman

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

d. STREET ADDRESS

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Addie Middle V. Last MARTIN

4. DATE OF DEATH Month November Day 7 Year 1959

5. SEX Fe

6. COLOR OR RACE W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Dec. 23, 1886

9. AGE (In years last birthday) 72 yrs.

IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Housework

11. BIRTHPLACE (State or foreign country) MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME Edwin Tyler

14. MOTHER'S MAIDEN NAME Rose Cummings

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service) NONE

16. SOCIAL SECURITY NO. UKN.

17. INFORMANT Address HOSPITAL RECORDS, EASTON, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH 4 days

332X

DUE TO (b)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov 2 19 59, to Nov 7 19 59, that I last saw the deceased alive on Nov 2 19 59, and that death occurred at 7:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. ADDRESS (Street, city or town, state) Easton, Maryland DATE SIGNED Nov 9 59

PHYSICIAN'S NAME (Type) THURSTON HARRISON

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 11-10-59

22c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery

22d. LOCATION (City, town, or county) (State) Baltimore, Md.

23. FUNERAL DIRECTOR'S SIGNATURE Leonard J. Ruck ADDRESS 5303 Harford Rd. Baltimore, Md.

24a. REC'D BY REGISTRAR DATE NOV 12 '59

24b. REGISTRAR'S SIGNATURE Clinton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13014

CERTIFICATE OF DEATH

13005

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Queen Anne

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 25 yr

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Centreville Rural #1

d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION Easton Memorial Hospital
d. STREET ADDRESS 17 x 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Yvonne Middle Lost Newton

4. DATE OF DEATH Month Nov Day 5 Year 1959

5. SEX F
6. COLOR OR RACE Col
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH Oct 17 1959
9. AGE (In years lost birthday) yrs.
IF UNDER 1 YEAR Months Days 19
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None
10b. KIND OF BUSINESS OR INDUSTRY None
11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME John Edward Newton
14. MOTHER'S MAIDEN NAME Grace R. Green

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mother Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia — INTERVAL BETWEEN ONSET AND DEATH 2 da
768.0
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Septicemia (overwhelming) — 2 da
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11-5, 19 59, to 11-5, 19 59, that I last saw the deceased alive on 11-5, 19 59, and that death occurred at 10 pM, from the couses and on the date stated above.

ACTUAL SIGNATURE John E Baylutt M.D.
ADDRESS (Street, city or town, state) 205 Earle Ave Easton, Maryland
DATE SIGNED
PHYSICIAN'S NAME (Type)

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Nov 8 59
22c. NAME OF CEMETERY OR CREMATORY Bunnville
22d. LOCATION (City, town, or county) Rural Centreville (State) Maryland

23. FUNERAL DIRECTOR'S SIGNATURE Barton Bros
ADDRESS N. Easton Bus Centreville Md
2080225XV4

24a. REC'D BY REGISTRAR DATE NOV 13 '59
24b. REGISTRAR'S SIGNATURE Curtis S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13006

CERTIFICATE OF DEATH

13015 Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 30 da.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: Wicomico ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Delmar 22x-2
d. STREET ADDRESS: RT#3
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

080

3. NAME OF DECEASED (Type or print): First Patricia Middle Elnora Last PARSONS
4. DATE OF DEATH: Month Nov. Day 29 Year 1959
5. SEX: Fe
6. COLOR OR RACE: W
7. MARRIED [ ] NEVER MARRIED [X] WIDOWED [ ] DIVORCED [ ] Single
8. DATE OF BIRTH: Nov. 26, 1945
9. AGE (In years last birthday): 14 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): School Girl
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Salisbury MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Raymond THOMAS XXX Parsons
14. MOTHER'S MAIDEN NAME: Elizabeth MAE Hill

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Address: Mr. Raymond T. Parsons (Father) R.D.# 3 Delmar, Maryland

I

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Nephrosis — INTERVAL BETWEEN ONSET AND DEATH: 6 years
591X
DUE TO
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause last.
(b)
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work [ ] Not while at work [ ]
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on Nov. 19, 19__, and that death occurred at 9:35 A. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: E. C. H. Schmidt M.D.
ADDRESS (Street, city or town, state): 219 S. Washington ST. Easton, Maryland
DATE SIGNED: 29 Nov 59
PHYSICIAN'S NAME (Type): E. C. H. Schmidt

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Dec. 2, 1959
22c. NAME OF CEMETERY OR CREMATORY: Parsons Cemetery
22d. LOCATION (City, town, or county) (State): Salisbury, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND
24a. REC'D BY REGISTRAR DATE: DEC 2 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to buriol, cremation, or removol, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13016

13007

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 1day
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bozman.
d. STREET ADDRESS: —
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Gilbert — Last: Poore, SR.

4. DATE OF DEATH: Month: November — Day: 5 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 26, 1897

9. AGE (In years last birthday): 62 yrs.

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): DISABLED VETERAN-U.S.ARMY

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Delaware

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alfred Poore

14. MOTHER'S MAIDEN NAME: Laura Chaires

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: wife -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Coronale — 3 years
DUE TO (c): Arthritis — 30+ yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

241X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year: Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4 Weeks 19 59 to Nov 19 59, that I last saw the deceased alive on Nov 19 59, and that death occurred at 8:40P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: K. Kane Wirth M.D. ADDRESS (Street, city or town, state): Box 487, St. Michaels, Md DATE SIGNED: 11-6-59

PHYSICIAN'S NAME (Type):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov 8, 1959

22c. NAME OF CEMETERY OR CREMATORY: Bozman Cemetery

22d. LOCATION (City, town, or county) (State): Bozman, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: L. Hamilton Harrison, St. Michaels, Md

24a. REC'D BY REGISTRAR DATE: NOV 10 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/SS

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13008

Item 22-B, Rilm G253 12/4/59 iwk

13029

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): TRAPPE
c. LENGTH OF STAY IN 1b: Life
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION:

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE: MARYLAND — b. COUNTY: talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): × TRAPPE, Md
d. STREET ADDRESS: /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ELLEN — Middle: LOUISE — Last: Roberts

4. DATE OF DEATH: Month: 11 — Day: 14 — Year: 1959

5. SEX: Female

6. COLOR OR RACE: Col

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 4/2/18

9. AGE (In years last birthday): 41 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (State or foreign country): MARYland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles Roberts

14. MOTHER'S MAIDEN NAME: IdA MAE JACKSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Metastatic Carcinoma — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Carcinoma of right breast — 6 mos.
DUE TO
(c):

170 ×

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Sept, 1959, to 14 Nov, 1959, that I last saw the deceased alive on 12 Nov, 1959, and that death occurred at ____ M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Edwin Fassett, M.D. — ADDRESS (Street, city or town, state): 227 Pine St. — DATE SIGNED:

PHYSICIAN'S NAME (Type): J. Edwin Fassett — Cambridge, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11/18/1959

22c. NAME OF CEMETERY OR CREMATORY: TRAPPE Cem

22d. LOCATION (City, town, or county) (State): TRAPPE Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James L. Hosfield — ADDRESS: Easton, Md.

24a. REC'D BY REGISTRAR: DATE REC 1 '59

24b. REGISTRAR'S SIGNATURE: Anthony L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 8 FilmG252 12-1-59 et

13017

13009

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eas[illegible]
c. LENGTH OF STAY IN 1b DOA
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland — b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Newcomb
d. STREET ADDRESS /
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First: Charles — Middle: Rigby — Last: Ross

4. DATE OF DEATH Month: November — Day: 23 — Year: 1959

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Feb. 11 1895

9. AGE (In years last birthday) 64 yrs. — IF UNDER 1 YEAR Months: 8 Days: [illegible] — IF UNDER 24 HRS. Hours: [illegible] Min.: [illegible]

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Mechanic

10b. KIND OF BUSINESS OR INDUSTRY Auto

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME Adoni Ross

14. MOTHER'S MAIDEN NAME Martha A. Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. 217-28-4706

17. INFORMANT Mrs C. R. Ross. — Address Fluvanna, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH: 1 HR.
420.0
DUE TO
(b) Arteri - Sclerotic Heart Disease — Years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from JUNE, 1955, to NOV. 23, 1959, that I last saw the deceased alive on NOV. 23, 1959, and that death occurred at 10 P. M, from the causes and on the date stated above.

ACTUAL SIGNATURE Donald F. Barnley, M.D. — ADDRESS (Street, city or town, state) 9 N. HANSON ST. EASTON, MD. — DATE SIGNED 11-23-59

PHYSICIAN'S NAME (Type) DONALD F BARNLEY

22a. BURIAL, CREMATION, REMOVAL (Specify) — 22b. DATE THEREOF Nov. 27, 59 — 22c. NAME OF CEMETERY OR CREMATORY Spring Hill Cemetery — 22d. LOCATION (City, town, or county) (State) Easton, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE [illegible] — ADDRESS Easton Md.

24a. REC'D BY REGISTRAR DATE NOV 27 '59 — 24b. REGISTRAR'S SIGNATURE [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 12 FilmG252 11-16-59 et

13018

13010

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton.
c. LENGTH OF STAY IN 1b: 11days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Easton
d. STREET ADDRESS: RFD #2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

080

3. NAME OF DECEASED (Type or print): First Frank Middle Lost Saathoff
4. DATE OF DEATH: Month November Day 6 Year 1959
5. SEX: M
6. COLOR OR RACE: W
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: December 10 1877
9. AGE (In years last birthday): 81 yrs.
IF UNDER 1 YEAR: Months ____ Days ____ IF UNDER 24 HRS.: Hours ____ Min. ____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Farming
11. BIRTHPLACE (State or foreign country): Germany
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: George Saathoff
14. MOTHER'S MAIDEN NAME: Sadie Saathoff
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT: Mrs Hilda Jelkin Address: Saathoff R#2 Easton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac failure
DUE TO (b): Coronary atherosclerosis
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
420.1
INTERVAL BETWEEN ONSET AND DEATH: a. 10 yr

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan, 1950, to Nov, 1959, that I last saw the deceased alive on Nov, 1959, and that death occurred at 5:25 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Thurston Harrison M.D. ADDRESS (Street, city or town, state): Easton Maryland DATE SIGNED: 6 Nov 59
PHYSICIAN'S NAME (Type): THURSTON HARRISON

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: Nov 9, 1959
22c. NAME OF CEMETERY OR CREMATORY: Woodlawn Memorial
22d. LOCATION (City, town, or county) (State): Rt 50 - Easton Md
23. FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: Easton Md.
24a. REC'D BY REGISTRAR DATE: NOV 12 '59
24b. REGISTRAR'S SIGNATURE: Emilie S. Travis

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13030 Item 3 FilmG252 11-17-59 et

CERTIFICATE OF DEATH

Reg. Dist. No. 13011

1. PLACE OF DEATH a. COUNTY Talbot MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova
c. LENGTH OF STAY IN 1b 5 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cordova
d. STREET ADDRESS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First Ola Middle Madge (Sands) Last Hanes
4. DATE OF DEATH Month Nov. Day 6 Year 1959
5. SEX F. 6. COLOR OR RACE W. 7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH April 23 1888 9. AGE (In years last birthday) 71 yrs.
IF UNDER 1 YEAR Months 6 Days 13 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Own Home
11. BIRTHPLACE (State or foreign country) Michigan
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Arthur John Dean
14. MOTHER'S MAIDEN NAME Emma Jane Bowser

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 219-34-3015
17. INFORMANT Mrs Oshel Dukin Address Cordova

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart failure — INTERVAL BETWEEN ONSET AND DEATH 3 Days
420.0
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Hypertonic Heart Disease. — years
DUE TO (c) Arteriosclerotic Heart Disease — years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Generalized Arteriosclerosis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June, 1956, to Nov. 4, 1959, that I last saw the deceased alive on Nov 4th, 1959, and that death occurred at [illegible] A.M., from the causes and on the date stated above.
ACTUAL SIGNATURE Charles H Winnacott M.D. ADDRESS (Street, city or town, state) Ridgely, Maryland DATE SIGNED
PHYSICIAN'S NAME (Type) CHARLES H. WINNACOTT Ridgely, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Nov. 8 59
22c. NAME OF CEMETERY OR CREMATORY Greenmount
22d. LOCATION (City, town, or county) Baltimore (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE A. Ellis Cook ADDRESS Easton, Md
24a. REC'D BY REGISTRAR DATE NOV 12 '59
24b. REGISTRAR'S SIGNATURE Catherine S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/55

1 X

FOR STATE HEALTH DEPT.

2:52 A.M.

13019

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13012

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 2/57

080

1. PLACE OF DEATH — a. COUNTY: Talbot — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
   c. LENGTH OF STAY IN 1b: 9 Mo. 12 mins.
   d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): The Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Caroline ✓
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Federalsburg; 05 X-2
   d. STREET ADDRESS: NICHOLS ROAD
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norris — Middle: DICKERSON — Last: Scott

4. DATE OF DEATH: Month: November — Day: 30 — Year: 1959

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: February 28, 1923

9. AGE (In years last birthday): 36 yrs.

IF UNDER 1 YEAR: Months: ___ Days: ___ IF UNDER 24 HRS.: Hours: ___ Min.: ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: CAROLINE POULTRY FARMS, INC.

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? United States

13. FATHER'S NAME: Emanuel Scott

14. MOTHER'S MAIDEN NAME: Myrtle Dickerson

1

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): ~~Unknown~~ No

16. SOCIAL SECURITY NO.: 220-03-3526

17. INFORMANT — Address: MRS. IOLA OWENS, WILMINGTON, DELAWARE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

331 X

IMMEDIATE CAUSE (a): Cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 24 h.

DUE TO (b): Hypertensive — ?

DUE TO (c): ___

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: a. m. / p. m. — Month, Day, Year: 19

20d. INJURY OCCURRED — While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Dawson O. George M.D.

EXAMINER'S NAME (Type): DAWSON O. George

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 11-30-59

2

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: DEC. 5, 1959

22c. NAME OF CEMETERY OR CREMATORY: FEDERAL HILL CEMETERY

22d. LOCATION (City, town, or county) (State): FEDERALSBURG, MARYLAND

23. FUNERAL DIRECTOR'S SIGNATURE: J. J. Frampton and Son — ADDRESS: Federalsburg, Md.

24a. REC'D BY REGISTRAR — DATE: DEC 3 '59

24b. REGISTRAR'S SIGNATURE: Andrew S. Knowles

2

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13031

CERTIFICATE OF DEATH

Reg. Dist. No. 13013

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): St. Michaels
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: ----

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X St. Michaels
d. STREET ADDRESS: ----
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First FLORENCE — Middle SEWALL — Last SMITH

4. DATE OF DEATH: Month November — Day 4, — Year 19 59

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 26, 1866
9. AGE (In years last birthday): 93 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: ---
11. BIRTHPLACE (State or foreign country): Brookline, Mass.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: I. S. Getchell
14. MOTHER'S MAIDEN NAME: Morgiana Sewall

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service): ---
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Mrs. Eleanor F. S. Kerr, St. Michaels, Md. — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Embolus — INTERVAL BETWEEN ONSET AND DEATH: 30 min.
DUE TO (b): Cellulitis of Left Leg. — 48 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 693.4
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid Arthritis
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY: Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 3 Nov, 19 59 to 4 Nov, 19 59, that I last saw the deceased alive on 4 Nov, 19 59, and that death occurred at 3:50 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: R. Lane Wroth M.D. — ADDRESS (Street, city or town, state): Box 489, St. Michaels, Md. — DATE SIGNED: 5 Nov 59
PHYSICIAN'S NAME (Type): R. LANE WROTH, M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov 6, 1959
22c. NAME OF CEMETERY OR CREMATORY: Louden Park Cemetery
22d. LOCATION (City, town, or county) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: L. Hamilton Harrison — ADDRESS: St. Michaels, Md.
24a. REC'D BY REGISTRAR DATE: NOV 9 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13020

Reg. Dist. No. 14175

M

1. PLACE OF DEATH
a. COUNTY: TALBOTT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 9 HOURS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: MEMORIAL HOSPITAL, EASTON

080

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND b. COUNTY: QUEEN ANNES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Rt. 3 CENTREVILLE RURAL
d. STREET ADDRESS: Rt. #3 17X-2
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First GEORGE Middle — Last STANFORD

4. DATE OF DEATH: Month NOVEMBER Day 29, Year 1959

5. SEX: MALE
6. COLOR OR RACE: NEGRO
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 1/10/1885
9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): INVALID
10b. KIND OF BUSINESS OR INDUSTRY: —
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: GEORGE STANFORD
14. MOTHER'S MAIDEN NAME: SARAH SUTTON

I

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.: —
17. INFORMANT: WIFE - EMMA STANFORD Address: RT. 3 CENTREVILLE MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

420.1

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO (b): CORONARY AND GENERALIZED — 10 YEARS +

DUE TO (c): ARTERIOSCLEROSIS

2

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter noture of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Month, Doy, Year Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/28/1959, to 11/29/1959, that I last saw the deceased alive on 11/29/1959, and that death occurred at 12:20 A.M, from the causes and on the date stated above.

ACTUAL SIGNATURE: J. Kent Young M.D. — ADDRESS (Street, city or, town, state): 105 Chesterfield Ave. — DATE SIGNED:

PHYSICIAN'S NAME (Type): J. KENT YOUNG — Centreville Md.

1

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 12/2/59
22c. NAME OF CEMETERY OR CREMATORY: New Dawn Cem
22d. LOCATION (City, town, or county) (State): Cordova Md.

23. FUNERAL DIRECTOR'S SIGNATURE: James B Tarbill — ADDRESS: Easton Md.

24a. REC'D BY REGISTRAR DATE: DEC 10 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 22 & 1 Film G253 12/3/59 iwk

13032

CERTIFICATE OF DEATH

Reg. Dist. No. 13014

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ROYAL OAK
c. LENGTH OF STAY IN 1b: home of daughter
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: (Mrs. Scott Kilmon, daughter)

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: HOWARD ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ELLICOTT CITY - 13X-2
d. STREET ADDRESS: 40 ORCHARD DR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: — Last: Strohmer

4. DATE OF DEATH: Month: 11 — Day: 23 — Year: 1959

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JULY-9-1875

9. AGE (In years last birthday): 84 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOME

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (State or foreign country): BALTO Md

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: LORY

14. MOTHER'S MAIDEN NAME: FLORA

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): NO — (If yes, give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: MR. JOS G. STROHMER 600 2 Pinehurst Rd

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): carcinoma - sore - generalized — INTERVAL BETWEEN ONSET AND DEATH: 6 mos.
199.2
DUE TO
(b): adenocarcinoma tibia - generalized
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): cardiac failure-chronic. A.C.V.D.

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 9-28, 1955, to 11-23, 1959, that I last saw the deceased alive on 11-23, 1959, and that death occurred at 2:45 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Guy M Reese Jr M.D. — ADDRESS (Street, city or town, state): A Michaels Md — DATE SIGNED

PHYSICIAN'S NAME (Type): Guy M Reese Jr — 11-23-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Nov. 27, 1959

22c. NAME OF CEMETERY OR CREMATORY: Holy Redeemer Cem.

22d. LOCATION (City, town, or county) (State): Belmont Rd Balto Md

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: THOMAS J KENNY Inc 1600 Hollins St

24a. REC'D BY REGISTRAR DATE: NOV 30 '59

24b. REGISTRAR'S SIGNATURE: Cortlon S. Frank

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/SS

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13021

CERTIFICATE OF DEATH

Reg. Dist. No. 13015

1. PLACE OF DEATH
a. COUNTY TALBOTT MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) EASTON
c. LENGTH OF STAY IN 1b 1¼ hour
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL, EASTON

2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE DELAWARE b. COUNTY ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) WILMINGTON 8 46x.3
d. STREET ADDRESS 2402 NEWPORT GAP PIKE THE CEDARS
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒ ✓

3. NAME OF DECEASED (Type or print) First HELEN Middle E. Last TAYLOR

4. DATE OF DEATH Month NOVEMBER Day 30 Year 19 59

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH JUNE 29, 1884
9. AGE (In years last birthday) 75 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEKEEPER
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME WILLIAM TAYLOR
14. MOTHER'S MAIDEN NAME SARAH ELIZABETH HOUSTON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO (If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 162-28-18[illegible]
17. INFORMANT MRS. MARY BRISTOW Address 210 WASHINGTON AVE. WILMINGTON, DEL.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION — INTERVAL BETWEEN ONSET AND DEATH 3 DAYS
420.1
DUE TO (b) GENERALIZED ARTERIOSCLEROSIS — YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/30/, 1959, to 11/30/, 1959, that I last saw the deceased alive on 11/30/, 1959, and that death occurred at 2:15 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE J. Kent Young M.D. ADDRESS (Street, city or town, state) 105 Chesterfield Ave. DATE SIGNED
PHYSICIAN'S NAME (Type) J. KENT YOUNG Centreville Maryland

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 12/3/59
22c. NAME OF CEMETERY OR CREMATORY Offord Cemetery
22d. LOCATION (City, town, or county) Offord Chester Co. (State) Pa.

23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson ADDRESS Rising Sun Md
24a. REC'D BY REGISTRAR DATE DEC 8 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 3 FilmG257 2-26-60 et

13022

13016

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Easton
c. LENGTH OF STAY IN 1b 4 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 175 S. Hanson St.

2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission)
a. STATE Maryland — b. COUNTY Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 40 Easton
d. STREET ADDRESS 175 S. Hanson St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Thomas — Middle Hendrix (Twilley) — Last Twilley
4. DATE OF DEATH Month Nov — Day 8 — Year 1959
5. SEX M.
6. COLOR OR RACE W.
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH June 7 1883
9. AGE (In years last birthday) 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waiter
10b. KIND OF BUSINESS OR INDUSTRY Grocery Salesman
11. BIRTHPLACE (State or foreign country) Dorchester County Md
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME John Twilley
14. MOTHER'S MAIDEN NAME Josephine LeCompte

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No
(If yes, give war or dates of service)
16. SOCIAL SECURITY NO. 216-03-7574
17. INFORMANT Mrs. Mildred Price Twilley, Address 175 S. Hanson Easton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Stroke — INTERVAL BETWEEN ONSET AND DEATH 2 yrs
443X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) H C V D
DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from ____, 19__, to 11/8/, 19__, that I last saw the deceased alive on 11/8/, 19__, and that death occurred at 8 a.m., from the causes and on the date stated above.

ACTUAL SIGNATURE [signature] M.D. — ADDRESS (Street, city or town, state) Easton Md — DATE SIGNED

PHYSICIAN'S NAME (Type) P. E. Cox

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF Nov. 10, 59
22c. NAME OF CEMETERY OR CREMATORY Spring Hill
22d. LOCATION (City, town, or county) Easton (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE [signature] ADDRESS Easton Md

24a. REC'D BY REGISTRAR DATE NOV 12 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13023

CERTIFICATE OF DEATH

13017

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON
c. LENGTH OF STAY IN 1b: 3da
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND — b. COUNTY: Caroline
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Greensboro 05X-2
d. STREET ADDRESS: NONE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Judith — Middle: LYNN — Last: WARD

4. DATE OF DEATH: Month: 11 — Day: 18 — Year: 1959

5. SEX: fe

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-15-59

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months: — Days: 3 — IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: DAVID CAREY WARD

14. MOTHER'S MAIDEN NAME: JOYCE ANN Nichols

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.: —

17. INFORMANT — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Respiratory insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs
773.5
DUE TO (b): Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 11/15, 1959, to 11/18, 1959, that I last saw the deceased alive on 11/18, 1959, and that death occurred at 1 p. M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Barbara Williams M.D. M.D. — ADDRESS (Street, city or town, state): 205 Earle Ave, Easton — DATE SIGNED: 11/20/59

PHYSICIAN'S NAME (Type): Barbara Williams M.D. — 205 Earle Ave. Easton, Md. 11/20/59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 11-19-59

22c. NAME OF CEMETERY OR CREMATORY: Greensboro

22d. LOCATION (City, town, or county) (State): Greensboro Md.

23. FUNERAL DIRECTOR'S SIGNATURE: J. E. Boulais — ADDRESS: Greensboro Md

24a. REC'D BY REGISTRAR DATE: NOV 23 '59

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

2080212XV3

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13024

CERTIFICATE OF DEATH

Reg. Dist. No. 13018

1. PLACE OF DEATH
a. COUNTY: Talbot — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Easton
c. LENGTH OF STAY IN 1b: 19 yrs
d. NAME OF HOSPITAL (If not in hospitol, give street oddress) OR INSTITUTION: 207 E. Dover St.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Talbot
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 40 Easton
d. STREET ADDRESS: 207 E. Dover St
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Katherine — Middle: Josephine — Last: Wilis
4. DATE OF DEATH: Month: Nov. — Day: 29 — Year: 1959

5. SEX: F.
6. COLOR OR RACE: W.
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Feb. 16 1883
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housekeeper
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Hafle, Pennsylvania
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Flynn
14. MOTHER'S MAIDEN NAME: ? Riley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: none
17. INFORMANT: William Wilis — Address: Easton Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one couse per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis — INTERVAL BETWEEN ONSET AND DEATH: 3 mos
DUE TO (b): Carcinoma of the colon — (?)
DUE TO (c):
Conditions, if ony, which gave rise to immediate cause (a), stating the underlying cause last. 153.8

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Port I or Port II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Jan 1950, to 29 Nov 1959, that I last saw the deceased alive on 26 Nov 59, 19____, and that death occurred at 8:45 P.M. from the causes and on the date stated above.

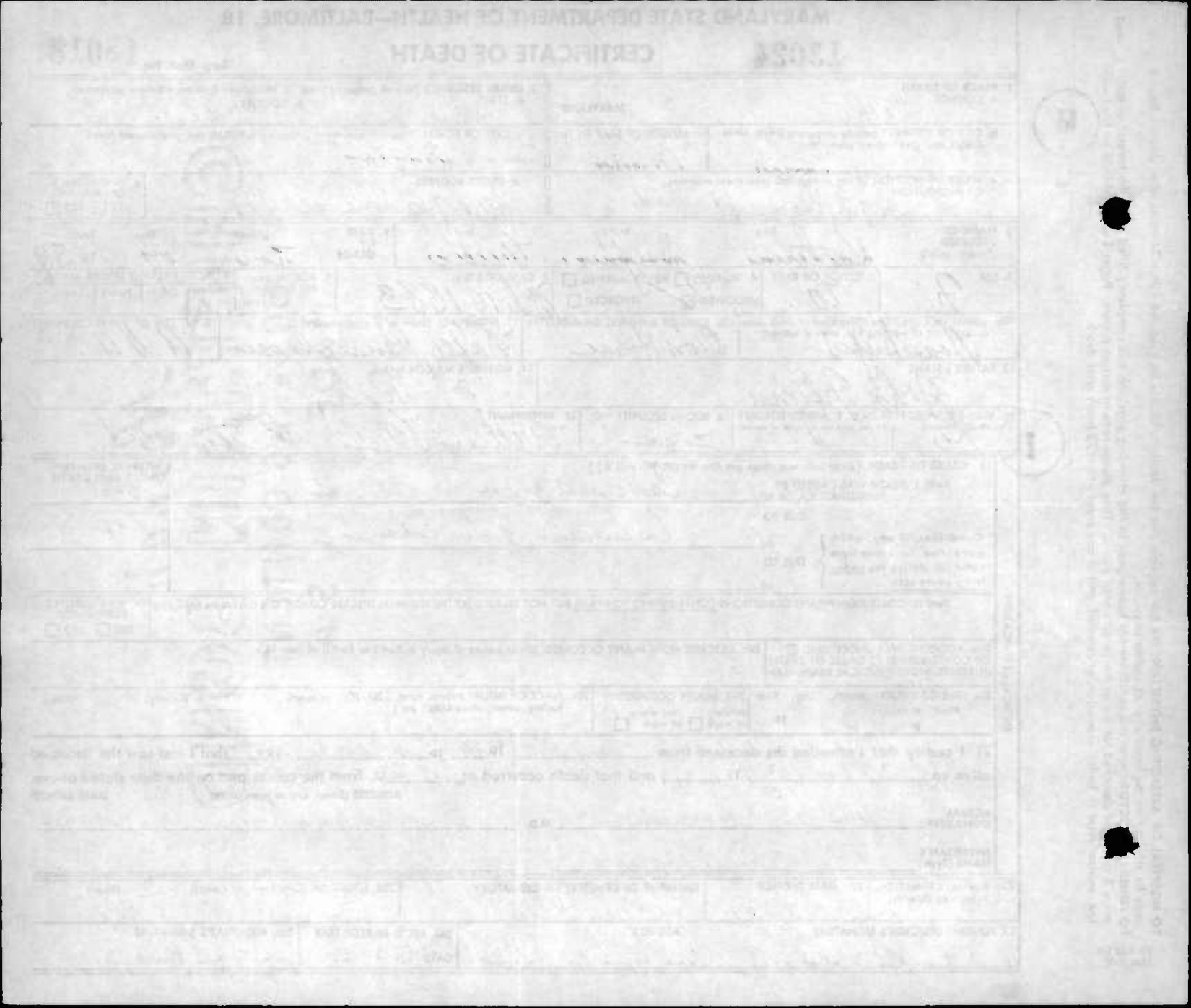
ACTUAL SIGNATURE: Thurston Harrison M.D. — ADDRESS (Street, city or town, state): Easton, Talbot County, Md. — DATE SIGNED: 30 Nov 59
PHYSICIAN'S NAME (Type): THURSTON HARRISON

22a. BURIAL, CREMATION, REMOVAL (Specify)
22b. DATE THEREOF: Dec 1959
22c. NAME OF CEMETERY OR CREMATORY: Spring Hill
22d. LOCATION (City, town, or county) (State): Easton Md

23. FUNERAL DIRECTOR'S SIGNATURE: Ellis Clark — ADDRESS: Easton Md
24a. REC'D BY REGISTRAR DATE: DEC 3 '59
24b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13033 Item 7 FilmG252 12-1-59 et 13019 Reg. Dist. No.

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: TALBOT — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): EASTON RURAL
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: MARYLAND b. COUNTY: CAROLINE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): RIDGELY 05X-2
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN Middle G Last WILSON
4. DATE OF DEATH: Month NOV Day 20 Year 1959
5. SEX: MALE
6. COLOR OR RACE: W
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: AUG. 26, 1915
9. AGE (In years last birthday): 44 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERICAL
10b. KIND OF BUSINESS OR INDUSTRY: CAROLINE CO.
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: NORMAN WILSON
14. MOTHER'S MAIDEN NAME: SARA ELMA DAVIS

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: James Wilson Address: Ridgely, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): PARTIAL DECAPITATION — INTERVAL BETWEEN ONSET AND DEATH
823X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): AUTO ACCIDENT
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): DRIVER OF CAR LEFT ROAD JUMPED STREAM CRASHED
20c. TIME OF INJURY Hour: about 4:30 p.m. Month, Day, Year: NOV 20 1959
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): HI WAY
20f. (City or town) NR EASTON (County) TALBOT (State) MD

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☐, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Louis O'Welty M.D.
EXAMINER'S NAME (Type): WELTY
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 11-20-59

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Nov. 24, 1959
22c. NAME OF CEMETERY OR CREMATORY: Greensboro
22d. LOCATION (City, town, or county) Greensboro (State) Md

23. FUNERAL DIRECTOR'S SIGNATURE: J. Virgil Crooks & Son ADDRESS: Easton Md
24a. REC'D BY REGISTRAR DATE: NOV 25 '59
24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
BM 2/57